AHRQ Safety Program for Intensive Care Units: Preventing CLABSI and CAUTI

Transcript

How To Empower Nurses To Effectively Implement a Nurse-Driven Protocol for Removing Urinary Catheters, Including How To Obtain Buy-In From Physicians

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[*Opening music*]

Kate Schmidgall: This audio interview is a production of the Agency for Healthcare Research and Quality. It is part of its toolkit for the Comprehensive Unit-based Safety Program, or CUSP, for intensive care units. I'm Kate Schmidgall, and I'm here with Pat Posa, Registered Nurse and Quality Excellence Leader at St. Joseph Mercy Health System.

Today, we're discussing how to empower nurses to effectively implement a nurse-driven protocol for removing urinary catheters, including how to obtain buy-in from physicians. Pat, welcome.

Pat Posa: Thanks, Kate. Glad to be here.

Kate: So, let's get started. In order to decrease the amount of catheter days, who should be asking, is this catheter still necessary?

Pat: The team should be asking. And it should be — so any member of the team, but if it's everyone's responsibility then it's kind of no one's responsibility. So, we have incorporated that question into our interdisciplinary rounds that occur each day on our ICU units. And so, it happens to be part of the nurse's script

that they will go over lines and tubes, and part of that is, do we still need these? So, the question gets asked. So, that's an effective way to ensure that you're thinking about it every day. Do they need the central line? Do they need restraints? Do they need this urinary catheter? Do they need these IVs? Do they need anything that's attached to them? Because it should be adding value to the care of the patient. And when it no longer is necessary, it needs to be removed. So, incorporating it into interdisciplinary rounds is a good thing.

Where you might find resistance in “can we remove this” is people's varying opinion on whether or not it's necessary. In critical care especially, the indication in critical care that is typically used as “why I have this catheter in” is to monitor intake and output in the critically ill patient. That can be achieved in a variety of ways. The easiest way to get the most accurate is to have a urinary catheter in place to measure that urine output, but it can be achieved other ways. And so, it's really about having the question of, is this really necessary?

Could we use an alternative, still collecting the urine and measuring it and getting an accurate output some other way than a urinary catheter? If they void every 2 to 4 hours, is that going to be good enough for you to clinically assess how they're doing? And that's where the conversations occurred in our CUSP team with physicians and the physician champions there having those conversations on, is this really necessary, and is there another way?

Moving to putting in a nurse-driven protocol is a great idea because those conversations at rounds are occurring one time during the day. Maybe at that point in time, it's not right, but 10 hours from now, it might be OK. But no one's going to have a conversation then because rounds are until 10 hours later. So, you have the opportunity with having that nurse-driven protocol to be able to remove that catheter when it's not been something that's been either discussed on rounds or the person wasn't ready then.

The biggest challenge is helping people understand that there is that threshold between when I need hourly outputs or every-2-hour outputs to guide my decision making on a critically ill patient versus I'm not making hourly decisions anymore. I could use — as long as I knew how much they voided every shift would be good enough. Then I don't need that same tool that I did to get that hourly. So, it's having that conversation because it was always there, so I didn't even have to think about that, that there is a transition period where I don't really need to know this information hourly or every other hour.

Kate: Is there anything to the idea that we need to clarify that catheter removal is in the best interest of the patient because it decreases risk, but it's also in the best interest of the team because it moves us closer to lower infection rates?

Pat: So, I think that it's always important to have the team understand why an intervention is necessary. So, it's important as you start any change in practice. People have to understand the why.

And with urinary catheters, one of the things that people don't always think about is the surrounding impact of having that urinary catheter in on potential patient harm. Having the urinary catheter in will limit that patient's mobility. Right? So, lack of mobility leads to deconditioning, which leads to, this person might not be able to care for themselves. Maybe they can't go home, they have to go to a skilled nursing facility, or they're too weak to — they're weaker and when they do try and get up, they fall, or they have a urinary catheter in and they try and get up and they trip over it. Or having that urinary catheter in, we know having any type of restraint — and that's a restraint, I can't move freely if I have that in — can increase the risk for delirium.

So, there are, besides even infection as an untoward consequence of having a urinary catheter in, there are number of other things that this can lead to. And so, if the clinical staff understand what potential harm can come from having this device in, then they're going to be more supportive of, oh, yeah, well I should take this out. This is important to get out because it can lead to all these other things, too, besides an infection.

Kate: And then in the same token, there's a new acceptance of the care that would need to be provided if they didn't have a catheter. For instance, you would need to get a bedpan or a nurse might need to pay more frequent visits in order to help them.

Pat: Yeah, and that's actually probably the biggest challenge on the nursing end.

With it not in place, now I'm having to either do a bedpan, but you really want to get the patient up. And so, every time they need to void, then I'm having to get them up, which takes more time. But if the people caring for the patient realize that that's a good thing, we want them to get up, those are all important things, and we give them the right tools and resources to be able to do that.

Even, again going back to, you've got to make it easy to do the right thing. If you want me to remove this, then you have to give me tools that I can either use an alternative if I need to collect accurate I & O but just not in the frequency of

having a urinary catheter, so I need tools, and then I need support to be able to then mobilize this patient more frequently because they're going to be going to the commode. You have to make sure that then you have the right structure and support in the unit so that when I remove that catheter, it's not an extra burden. It's, OK, this is just how we do it.

You know you need to have appropriate alternatives. So, if I do need to collect a more accurate I & O, on the male end there are a number of alternatives. There are just newly recent on the market some female alternatives to more accurately collect urine output. But there are other ways if someone is incontinent: pads that are very absorbent, wick away, that you can then measure and weigh. And they weigh pads and diapers in NICUs forever and recorded accurate outputs as a result of that. So, there are ways, but then you would have to make sure that you have those absorbent pads, and then you would need to have scales available. So, you would need to have those tools available.

And those are conversations that you would have in your CUSP team. Right? So, in the CUSP team, you would have to say, OK, in order for this to be easy for you to do, what are going to be the barriers and what are you going to need to make this easy to do? You know, so if I'm going to put in a nurse-driven protocol, part of that protocol is the ability to bladder scan after I remove the urinary catheter to be able to know if the patient is retaining, because that's your biggest fear. When you remove that catheter, has the bladder wall become weakened, and is that patient going to retain urine that sets them up for bladder damage as well as harboring organisms and they're growing inside the urine that's being retained? And so, you need to have the ability to scan and see how much volume is in the bladder to know whether or not you have to intervene or is this patient going to be able to do it on themselves.

So, if you're going to have an effective urinary catheter removal protocol, the equipment can't be three floors up. I'm not going to do it if I have to call up and get it from — if three ICUs are sharing the same bladder scanner. It's just not going to work.

Through the process, you have to ensure that you have physician support. That begins with your CUSP team where you have physician champions on there. They have to support it. For a urinary protocol, you usually have to get urology involved, right, because they're the experts, the urologists. So, they need to weigh in on its appropriateness. They're going to be a great subject matter expert on it, and so you'll want to use them.

And then the physician community needs to know that this is going to happen and support it, and asking the question, what do you think the barrier for you will be or for your colleagues on having the nurse do this? And the nurse doesn't need an order from you to remove it. If they meet these criteria, the nurse will remove it. And they'll tell you that they've removed it, but they will remove it. And so, it's finding out what are their concerns, what would their issues be, and making sure that you deal with that within the protocol or within the education.

And if you don't have the conversation of, what do you think about this, what are your concerns, how will this not work, so how could this fail, if you don't in your CUSP team have those conversations, then you're going to hit barriers. You'll have to face it sometime, right? But it'll be after you've implemented. And so, by the prework of asking those questions, understanding from the staff, how will this fail or what do I need to make this successful, and putting those things in place, are going to prevent on the back end it failing or issues and noncompliance.

Kate: So, acclimating the physicians to a change in protocol is one aspect, but also, how do we engage the patients and their families in this type of conversation?

Pat: So, I think there's a great opportunity to engage the family, and the family can promote what we're trying to do and reinforce with the patient the importance of it.

And so, we have education sheets on, you have this in, these are the risks of having it in. And so, we're going to try and remove it as soon as we can, but we just want to let you know the risks. And we invite our families to join us on interdisciplinary rounds, so they're going to hear the conversations of, yes, it's time to take it out, no it's not. And when there's decisions to remove the catheters, the patient of course is told, but also that family is included in the conversation.

It was that transition occurred in the physicians to challenge themselves from their typical habit of just keeping it in because it was easy and I would get — I knew that number and I knew it would be right, to, OK, there's other ways to get that number, and the risk of keeping it in to get it just right versus having it a few CCs off with using another method, probably that risk outweighs the benefit.

Kate: And that sounds like it's a key to obtaining buy-in from physicians.

Pat: They have their own “Aha.” They have their own “Aha” moment of, “Hmm, just because this is how I've always done it doesn't mean it's the best way now.”

[*Closing music*]

Kate: Fantastic. Pat, thanks so much for your time. Thanks for joining me today.

Pat: You're welcome.

Kate: This has been a production of the Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services. Special thanks to Pat Posa for joining us today. To learn more about safety issues and ICUs, and CUSP in general, visit ahrq.gov/hai.

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[*Recorded in 2018, reviewed in 2022*]

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